Q/A Report:

Alcohol is STILL a Drug: An Exploratory Webinar Series – December 2021

Presenter: Joseph Rosenfeld
Recorded on December 7, 2021

1. **How do you get insurance to pay for treatment for 90+ days if they are still using?**

   Great Question. The Affordable Care Act requires that SUD services (and mental health services) be reimbursed equitably with all other medical conditions. Insurance companies have been ignoring this and there are a bunch of lawsuits working their way through the system. See the link below. Of course, insurance companies will stall as long as they can.
   https://www.jdsupra.com/legalnews/u-s-department-of-labor-settles-9787697/

   In addition, we providers have some responsibility as well. We have been very passive in the face of this discrimination. We need to educate the public at large and our consumers about the science of AUD/SUD treatment. We also need to work more closely with advocacy groups like Faces and Voices in Recovery.

   People in recovery have always had to fight for non-judgemental recognition. That will continue for at least another generation.

2. **I would like to see a webinar on how/why AUD starts & continues in some people and not in others. Are there common psychiatric diagnoses that people are self-medicating for? How many with AUD have FASD. There is a study done by CAMH in Toronto Canada of school kids and it found up 3%. Popova (CAMH) said it's likely the results of this study reflect how widespread FASD is in similar large cities in Canada. However, much higher rates are found in northern (Indigenous) communities and among children in care and those in jail or mental-health institutions, she said.**

   The aetiology of AUD/SUD is complicated and varies person to person. There are many very good articles on the subject. For some it appears to be genetic, for some the result of self-medication of a psychiatric disorder, and for some the result of environmental influences. I teach my students that providers must trace the

origins of a person's AUD/SUD and the create a treatment plan that addresses it back to its source. Failure to do so will lead to a return to use. Treating every client the same is not evidence supported.

https://www.shatterproof.org/learn/addiction-basics/science-of-addiction?gclid=EAIaIQobChMI_-P155jS9AIVEg_nCh2uKQF-EAAYBCAAEgI2xvD_BwE

https://www.recovery.org/addiction/causes/

I just read a very good book that addresses this in part, The Neuroscience of Addiction, by Francesca Mapua Filby (2019)

Children of people with an SUD/AUD have about a 20% chance of developing an AUD/SUD, versus the general population that has about a 5% chance.

FASD is a very serious and well documented disability.

3. **Curious about where harm reduction fits in with these models and practices. For example, the "Sober Curious" movement is growing.**

Harm Reduction fits very well into the last two bullet points of the last slide. Integrated systems of care, and ROSC both endorse outreach to people who are not yet ready to enter treatment. There are many forms of Harm Reduction for people not ready to enter recovery. Harm Reduction entails far more than needle exchange programs.

https://drugpolicy.org/issues/harm-reduction

I love Sober Curious, but it is more of a mutual aid entity or as you stated a movement than an intervention operated by a treatment program.

Motivational Interviewing supports client autonomy and decision-making regarding their own recovery. In my practice, if a client wants to explore controlled drinking, or a period of abstinence followed by a return to use I will work with them to plan it out. Again, this is an evidence supported intervention. You will not retain a person in treatment if you use "My way or the Highway" approaches.